276 Health Care Claim Status Request-4010X093A1 Implementation Format

HIPAA-EDI Health Care-Claim Status Request

Version: 1.0 Draft

Author:	**EDS for MEDI-CAL**
Publication:	**July 26, 2004**
Trading Partner:	**(Provider or Clearinghouse)**
Created:	**05/12/2004**
Modified:	**08/18/2004**
Current:	**08/17/2004**

Table of Contents

276 Health Care Claim Status Request

Functional Group=HR

This Companion Guide contains the format and establishes the data contents of the Health Care Claim Status Request Transaction Set (276) for use within the context of an Electronic Data Interchange (EDI) environment. A provider, recipient of health care products or services, or their authorized agent can use this transaction set to request the status of a health care claim or encounter from a health care payer. This transaction set is not intended to replace the Health Care Claim Transaction Set (837), but rather to occur after the receipt of a claim or encounter information. The request may occur at the summary or service line detail level.

MEDI-CAL NOTE:

The 276 transaction is designed to transmit one or more claim inquiries for each service provider. The hierarchy of the looping structure is information source (payer), information receiver (sender), service provider, subscriber (insured), and dependent. Information receivers who sort claim inquiries using this hierarchy will use the 276 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

This standard will allow for the submission of claim inquiries from providers of health care products and services to a Managed Care organization or other payer. Medi-Cal cannot process other types of transactions (i.e. 837, 270) submitted in the same file as 276 transactions. These other types of X12N transactions must be submitted separately using separate links on the Medi-Cal Web site.

COMPANION GUIDE DISCLAIMER:
The California Department of Health Service (DHS) has provided this DRAFT Medicaid Companion Document for the 276 Health Care Claim Status Request ASC X12N transaction and associated addendum (004010X093A1) to assist providers, clearinghouses and all covered entities in preparing HIPAA-compliant transactions. This document was prepared using the Addendum version of the transaction. DHS has focused primarily on the rules and policies regulating the submission of Medi-Cal data that is provided within this Companion Guide document.
The information provided herein is believed to be true and correct based on the Addenda Version of the HIPAA guidelines. These regulations are continuing to evolve; therefore, DHS makes no guarantee, expressed or implied, as to the accuracy of the information provided herein. Furthermore, this is a living document and the information provided herein is subject to change as DHS policy changes or as HIPAA legislation is updated or revised.

DHS NOTE:
The 276 Health Care Claim Status Request ASC X12N (004010X093A1) Implementation Guide (IG) transaction has been established by Health and Human Services as the standard for Claim Status Request compliance under HIPAA.
The Companion Guide, which is provided by DHS, outlines the required format for a Health Care Claim Status Request for Medi-Cal Fee-For--Service and other health care claims processed by the Fiscal Intermediary, EDS, on behalf of DHS.
It is important that providers and submitters study the Companion Guide and become familiar with the data that will be received by Medi-Cal in the transmission of a 276 Health Care Claim Status Request transaction.
This Companion Guide does not modify the standards; rather, it puts forth the subset of information from the IG that will be required for processing transactions. It is important that providers use this Companion Guide as a supplement to the IG. Within the IG, there are data elements that have many different qualifiers available for use. Each qualifier identifies a different piece of information.
This document omits code qualifiers that are not necessary for Medi-Cal processing. Although not all available codes are listed in this document, DHS will accept any codes named or listed in the HIPAA Implementation Guides.
When necessary, a "Medi-Cal NOTE" is included to describe specific Medi-Cal requirements. These notes provide guidance to ensure proper processing of the transaction.
It is important to understand that Medi-Cal has excluded situational loops and/or segments that are not relevant to the business requirements of Medi-Cal. The provider is advised to refer to the IG, which lists all loops, segments, and elements. The Companion Guide may omit some of the previously mentioned IG items, unless they are defined as required in the IG, or the situation requires their use for Medi-Cal processing. Providers are encouraged to use the IG to understand the positioning of the data examples provided for every segment, since our Companion Guide may not list all the elements.

PROCESSING SCHEDULE:
Medi-Cal adjudicates claims on a weekly basis. Health Care Claim Status Requests can be uploaded to the Medi-Cal Web site daily between 2 a.m. and midnight. Claim Status Requests will be processed Monday through Friday and the responses will be available on the Medi-Cal Web site the following day, if the request is received before the 6 p.m. cut-off. Claim Status Requests received after the 6 p.m. cut off on Friday night will be processed the following Monday night. Claim status responses will be available for 14 days.

MEDI-CAL MATCHING CRITERIA
Medi-Cal will use one of the following search criteria in locating the claim for which the 276 Health Care Claim Status Inquiry is being submitted:

Search Criteria 1
a) Service Provider ID found in Provider Identifier (Loop 2100C, NM109)
b) Subscriber ID (Loop 2100D, NM109)
c) Claim Control Number found in Payer Claim Control Number (Loop 2200D, REF02)

Medi-Cal requests the Payer Claim Control Number to be submitted if available, as this provides the most positive identification of the claims being queried.

Search Criteria 2
In the absence of the Payer Claim Control Number, Medi-Cal needs the following data elements in order to identify the claim(s) being queried:
a) Service Provider ID found in Provider Identifier (Loop 2100C, NM109)
b) Subscriber ID (Loop 2100D, NM109)
c) Service Line Date Period (Loop 2210D, DTP03)
d) Service Identification Code (Loop 2210D, SVC01-2)

Search Criteria 3
In the absence of 2210D Service Line Information, Medi-Cal needs the following data elements in order to identify the claim(s) being queried:
a) Service Provider ID found in Provider Identifier (Loop 2100C, NM109)
b) Subscriber ID (Loop 2100D, NM109)
c) Claim Service Period (Loop 2200D, DTP03)
d) Total Claim Charge Amount (Loop 2200D, AMT02)

No other data elements submitted on the Claim Status Request are used in the selection of claims to be returned on the 277 Claim Status Response.

Medi-Cal processes and pays claims at the line level for non-compound drug (pharmacy or medical supply), long term care, outpatient, medical, and vision claims, so the total claim charge used to inquire on these types of claims should be the billed amount for the CLAIM LINE. For inpatient, crossovers and compound drug claims, the total claim charge should be the billed amount for the entire claim, since these claim types are paid at a claim level.

Claim Status Responses are limited to 99 per Claim Status Inquiry at the claim or service level. It is recommended that providers and submitters limit their date ranges to the claim start and end dates of service. Medi-Cal will allow a 90-day range.

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required
010	ST	Transaction Set Header	M	1			Required
020	BHT	Beginning of Hierarchical Transaction	M	1			Required

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					>1		
010	HL	Information Source Level	M	1			Required
LOOP ID - 2100A					>1		
050	NM1	Payer Name	M	1			Required
LOOP ID - 2000B					>1		
010	HL	Information Receiver Level	M	1			Required
LOOP ID - 2100B					>1		
050	NM1	Information Receiver Name	M	1			Required
LOOP ID - 2000C					>1		
010	HL	Service Provider Level	M	1			Required
LOOP ID - 2100C					>1		
050	NM1	Provider Name	M	1			Required
LOOP ID - 2000D					>1		
010	HL	Subscriber Level	M	1			Required
040	DMG	Subscriber Demographic Information	O	1			Required
LOOP ID - 2100D					1		
050	NM1	Subscriber Name	M	1			Required
LOOP ID - 2200D					>1		
090	TRN	Claim Submitter Trace Number	O	1			Situational
100	REF	Payer Claim Identification Number	O	1			Situational
100	REF	Institutional Bill Type Identification	O	1			Situational
100	REF	Medical Record Identification	O	1			Situational
110	AMT	Claim Submitted Charges	O	1			Situational
120	DTP	Claim Service Date	O	1			Situational
LOOP ID - 2210D					>1		
130	SVC	Service Line Information	O	1			Situational
140	REF	Service Line Item Identification	O	1			Situational
150	DTP	Service Line Date	O	1			Situational

Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
160	SE	Transaction Set Trailer	M	1			Required

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

ISA   Interchange Control Header

Pos:	Max: 1
Heading - Mandatory	
Loop: N/A	**Elements: 16**

User Option (Usage): Required

The ISA is a fixed record length segment and all positions within each of the data elements must be filled.

Comments:

1. The first element separator (shown as '*' in the examples) defines the element separator to be used through the entire interchange request.
2. The segment terminator (shown as '~' in the examples) used after the ISA defines the segment terminator to be used throughout the entire interchange request.

Example:

ISA*000*..........*00*..........*ZZ*XYZ............*ZZ*610442.........*040220*0215*U*00401*123456789*0*P~
OR
ISA*000*..........*00*..........*ZZ*PRV123456......*ZZ*610442.........*040220*0215*U*00401*123456789*0*P~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
ISA01	I01	**Authorization Information Qualifier**	M	ID	2/2	Required	1
		Description: Code to identify the type of information found in the Authorization Information data element.					
		Code **Name**					
		00 No Authorization Information Present (No Meaningful Information in I02)					
ISA02	I02	**Authorization Information**	M	AN	10/10	Required	1
		Description: Information used for additional identification of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01).					
		MEDI-CAL NOTE: Space fill.					
ISA03	I03	**Security Information Qualifier**	M	ID	2/2	Required	1
		Description: Code to identify the type of information found in the Security Information data element.					
		Code **Name**					
		00 No Security Information Present (No Meaningful Information in I04)					
ISA04	I04	**Security Information**	M	AN	10/10	Required	1
		Description: This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03).					
		MEDI-CAL NOTE: Space fill.					
ISA05	I05	**Interchange ID Qualifier**	M	ID	2/2	Required	1
		Description: Code to identify system/method of code structure used in the Sender ID data element (I06).					
		Code **Name**					
		ZZ Mutually Defined					
ISA06	I06	**Interchange Sender ID**	M	AN	15/15	Required	1
		Description: Identification code published by the sender for other parties to use as the receiver ID to route data to them.					
		MEDI-CAL NOTE: Submitter ID or Billing Provider Number, left justify and pad with spaces.					
ISA07	I05	**Interchange ID Qualifier**	M	ID	2/2	Required	1
		Description: Code to identify the system/method of code structure used in the Receiver ID data element (I08).					
		Code **Name**					
		ZZ Mutually Defined					
ISA08	I07	**Interchange Receiver ID**	M	AN	15/15	Required	1
		Description: Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will					

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		use this as a receiving ID to route data to them.					
		MEDI-CAL NOTE: Receiver ID "610442", left justify and pad with spaces.					
ISA09	I08	**Interchange Date**	M	DT	6/6	Required	1
		Description: Date of the interchange request.					
		MEDI-CAL NOTE: Date is in YYMMDD format.					
ISA10	I09	**Interchange Time**	M	TM	4/4	Required	1
		Description: Time of the interchange request.					
		MEDI-CAL NOTE: Time is in HHMM format.					
ISA11	I10	**Interchange Control Standards Identifier**	M	ID	1/1	Required	1
		Description: Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer.					
		Code Name					
		U U.S. EDI Community of ASC X12, TDCC, and UCS					
ISA12	I11	**Interchange Control Version Number**	M	ID	5/5	Required	1
		Description: This version number covers the interchange control segments.					
		Code Name					
		00401 Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997					
ISA13	I12	**Interchange Control Number**	M	N0	9/9	Required	1
		Description: A control number assigned by the interchange sender. This data value must be identical with IEA02.					
		MEDI-CAL NOTE: A number, right justify and zero filled.					
ISA14	I13	**Acknowledgment Requested**	M	ID	1/1	Required	1
		Description: Code sent by the sender to request an interchange acknowledgment (TA1).					
		MEDI-CAL NOTE: Medi-Cal will only generate a TA1 Interchange Acknowledgement if the ISA or GS envelopes are invalid.					
		Code Name					
		0 No Acknowledgment Requested					
		1 Interchange Acknowledgment Requested					
ISA15	I14	**Usage Indicator**	M	ID	1/1	Required	1
		Description: Code to indicate data enclosed by this interchange envelope is production data.					
		Code Name					
		P Production Data					
		T Test Data					
ISA16	I15	**Component Element Separator**	M		1/1	Required	1
		Description: The component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure. You may use a Component Separator of your choice but it cannot be the same as the Data Element Separator or the Segment Terminator.					

GS Functional Group Header

<table>
<tr><td>Pos:</td><td>Max: 1</td></tr>
<tr><td colspan="2">Heading - Mandatory</td></tr>
<tr><td>Loop: N/A</td><td>Elements: 8</td></tr>
</table>

User Option (Usage): Required

Use this segment to indicate the beginning of a functional group and to provide control information.

Example:
GS*HR*XYZ*610442*20040305*1013*999999999*X*004010X093A1~
OR
GS*HR*PRV123456*610442*20040305*1013*999999999*X*004010X093A1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
GS01	479	**Functional Identifier Code**	M	ID	2/2	Required	1
		Description: Code identifying a group of application related transaction sets.					
		Code Name					
		HR Health Care Claim Status Request (276)					
GS02	142	**Application Sender's Code**	M	AN	2/15	Required	1
		Description: Code identifying party sending transmission.					
		MEDI-CAL NOTE: Medi-Cal Billing Provider Number or Submitter ID.					
GS03	124	**Application Receiver's Code**	M	AN	2/15	Required	1
		Description: Code identifying party receiving transmission.					
		MEDI-CAL NOTE: Medi-Cal Receiver ID "610442".					
GS04	373	**Date**	M	DT	8/8	Required	1
		Description: Use this date for the functional group creation date.					
		MEDI-CAL NOTE: Date is in format CCYYMMDD.					
GS05	337	**Time**	M	TM	4/8	Required	1
		Description: Use this time for the functional group creation time. Time expressed in 24-hour clock time, where H = hours (00-23), M = minutes (00-59).					
		MEDI-CAL NOTE: Time is in HHMM format.					
GS06	28	**Group Control Number**	M	N0	1/9	Required	1
		Description: Assigned number originated and maintained by the sender. This control number must be identical to the same data element in the associated functional group trailer, GE02.					
GS07	455	**Responsible Agency Code**	M	ID	1/2	Required	1
		Description: Code used in conjunction with Data Element 480 to identify the issuer of the standard.					
		MEDI-CAL NOTE: Code is 'X' for Accredited Standards Committee X12.					
		Code Name					
		X Accredited Standards Committee X12					
GS08	480	**Version / Release / Industry Identifier Code**	M	AN	1/12	Required	1
		Description: Code indicating the version, release, sub-release, and industry identifier of the EDI standard being used, including the GS and GE segments.					
		Code Name					
		004010X093A1 Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.					

ST Transaction Set Header

Pos: 010	**Max: 1**
Heading - Mandatory	
Loop: N/A	**Elements: 2**

User Option (Usage): Required

Use this segment to indicate the start of a transaction set and to assign a control number.

Example:
ST*276*0535~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
ST01	143	**Transaction Set Identifier Code** **Description:** Code uniquely identifying a Transaction Set. The transaction set identifier code is used by the translation routines of the interchange partners to select the appropriate transaction set definition.	M	ID	3/3	Required	1

Code Name
276   Health Care Claim Status Request

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
ST02	329	**Transaction Set Control Number** **Description:** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. This data value must be identical to SE02. **MEDI-CAL NOTE:** A user-assigned number. For example, start with 0001 and increment from there.	M	AN	4/9	Required	1

BHT Beginning of Hierarchical Transaction

Pos: 020	Max: 1
Heading - Mandatory	
Loop: N/A	**Elements: 3**

User Option (Usage): Required

Use this segment to define the business hierarchical structure of the transaction set and identify the business application purpose and reference data.

Example:
BHT*0010*13*20040214~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
BHT01	1005	**Hierarchical Structure Code**	M	ID	4/4	Required	1

Description: Use this code to specify the sequence of hierarchical levels that may appear in the transaction set. This code only indicates the sequence of the levels, not the requirement that all levels be present.

Code Name

0010   Information Source, Information Receiver, Provider of Service, Subscriber, Dependent

BHT02	353	**Transaction Set Purpose Code**	M	ID	2/2	Required	1

Description: Code identifying the purpose of the transaction set.

Code Name

13   Request

BHT04	373	**Date**	M	DT	8/8	Required	1

Description: This is the date the transaction set was created.

MEDI-CAL NOTE: Date is in CCYYMMDD format.

Loop 2000A

Pos: 010	**Repeat: >1**
Mandatory	
Loop: 2000A	**Elements: N/A**

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
010	HL	Information Source Level	M	1		Required
050		Loop 2100A	M		>1	Required

HL Information Source Level

User Option (Usage): Required

Use this segment to identify dependencies among and the content of hierarchically related groups of data segments.

Example:
HL*1*20*1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1
		Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. This ID shall contain a unique number for each occurrence of the HL segment in the transaction set.					
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1
		Description: Code defining the characteristic of a level in a hierarchical structure. This code indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction.					

Code Name
20   Information Source

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL04	736	**Hierarchical Child Code**	O	ID	1/1	Situational	1
		Description: Code indicating if there are hierarchical child data segments subordinate to the level being described. Because of the hierarchical structure, and because an additional HL always exists in this transaction, the code value in this data element at the Loop 2000A level should always be "1".					

Code Name
1   Additional Subordinate HL Data Segment in This Hierarchical Structure.

Loop 2100A

Pos: 050	**Repeat: >1**
Mandatory	
Loop: 2100A	**Elements: N/A**

Payers with multiple locations or multiple lines of business may require that the payer name be completed.

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
050	NM1	Payer Name	M	1		Required

NM1   Payer Name

User Option (Usage): Required

Use this segment to supply the full name of an individual or organizational entity.

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required

Example:

NM1*PR*2*MEDI-CAL*PI*610442~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required	1
		Description: Code identifying an organizational entity, a physical location, property or an individual.					
		Code **Name**					
		PR Payer					
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required	1
		Description: Code qualifying the type of entity.					
		Code **Name**					
		2 Non-Person Entity					
NM103	1035	**Name Last or Organization Name**	M	AN	1/35	Required	1
		Description: The Payer name.					
		MEDI-CAL NOTE: Must be "MEDI-CAL".					
NM108	66	**Identification Code Qualifier**	M	ID	1/2	Required	1
		Description: Code used to qualify the Identification Code submitted in NM109.					
		Code **Name**					
		PI Payor Identification					
NM109	67	**Identification Code**	M	AN	2/80	Required	1
		Description: Code identifying a party or other code. Use this number as qualified by the preceding data element NM108.					
		MEDI-CAL NOTE: Must be '610442'.					

Loop 2000B

<table>
<tr><td>Pos: 010</td><td>Repeat: >1</td></tr>
<tr><td colspan="2" align="center">Mandatory</td></tr>
<tr><td>Loop: 2000B</td><td>Elements: N/A</td></tr>
</table>

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
010	HL	Information Receiver Level	M	1		Required
050		Loop 2100B	M		>1	Required

HL Information Receiver Level

User Option (Usage): Required

Use this segment to identify dependencies among and the content of hierarchically related groups of data segments.

Example:
HL*1*1*21*1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1

Description: This ID shall contain a unique number for each occurrence of the HL segment in the transaction set. The value would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL02	734	**Hierarchical Parent ID Number**	M	AN	1/12	Required	1

Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1

Description: Code defining the characteristic of a level in a hierarchical structure. All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.

Code **Name**
21   Information Receiver

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL04	736	**Hierarchical Child Code**	M	ID	1/1	Required	1

Description: Code indicating if there are hierarchical child data segments subordinate to the level being described. Because of the hierarchical structure, and because an additional HL always exists in this transaction, the code value in this data element at the Loop 2000B level will always be "1".

Code **Name**
1   Additional Subordinate HL Data Segment in This Hierarchical Structure.

Loop 2100B

Pos: 050		**Repeat: >1**
	Mandatory	
Loop: 2100B		**Elements: N/A**

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
050	NM1	Information Receiver Name	M	1		Required

NM1   Information Receiver Name

<div style="border:1px solid">

Pos: 050   **Max: 1**
Detail - Mandatory
Loop: 2100B   **Elements: 8**

</div>

User Option (Usage): Required

Use this segment to supply the full name of an individual or organizational entity.

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required

Example:

NM1*41*2*CLAIM.SPECIALISTS****46*654372~
-OR-
NM1*41*1*JOHN*DOE**DR*46*1234567890~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required	1
		Description: Code identifying an organizational entity, a physical location, property or an individual.					
		Code **Name**					
		41 Submitter					
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required	1
		Description: Code qualifying the type of entity.					
		Code **Name**					
		1 Person					
		2 Non-Person Entity					
NM103	1035	**Name Last or Organization Name**	M	AN	1/35	Required	1
		Description: Individual last name or organizational name.					
NM104	1036	**Name First**	O	AN	1/25	Situational	1
		Description: Information Receiver first name.					
		MEDI-CAL NOTE: The first name is required when the value in NM102='1'.					
NM105	1037	**Name Middle**	O	AN	1/25	Situational	1
		Description: Information Receiver middle name or initial.					
		MEDI-CAL NOTE: The middle name is recommended when the value in NM102='1'.					
NM107	1039	**Name Suffix**	O	AN	1/10	Situational	1
		Description: Information Receiver name suffix.					
		MEDI-CAL NOTE: The name suffix is recommended if the value in NM102='1'.					
NM108	66	**Identification Code Qualifier**	M	ID	1/2	Required	1
		Description: Code used to qualify the Identification Code submitted in NM109.					
		Code **Name**					
		46 Electronic Transmitter Identification Number (ETIN)					
		FI Federal Taxpayer's Identification Number					
		XX Health Care Financing Administration National Provider Identifier					
NM109	67	**Identification Code**	M	AN	2/80	Required	1
		Description: Code identifying a party or other code. Use this number as qualified by the preceding data element NM108.					
		MEDI-CAL NOTE: Enter Electronic Transmitter ID (ETIN) or Federal Taxpayer ID. NPI for future use.					

Loop 2000C

Pos: 010	**Repeat: >1**
Mandatory	
Loop: 2000C	**Elements: N/A**

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
010	HL	Service Provider Level	M	1		Required
050		Loop 2100C	M		>1	Required

HL   Service Provider Level

User Option (Usage): Required

Use this segment to identify dependencies among and the content of hierarchically related groups of data segments.

Example:
HL*3*2*19*1~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1
		Description: A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. This ID shall contain a unique number for each occurrence of the HL segment in the transaction set. The value would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.					
HL02	734	**Hierarchical Parent ID Number**	M	AN	1/12	Required	1
		Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.					
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1
		Description: Code defining the characteristic of a level in a hierarchical structure. All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.					

Code Name
19   Provider of Service

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL04	736	**Hierarchical Child Code**	M	ID	1/1	Required	1
		Description: Code indicating if there are hierarchical child data segments subordinate to the level being described. Because of the hierarchical structure, and because an additional HL always exists in this transaction, the code value in this data element at the Loop 2000B level will always be "1".					

Code Name
1   Additional Subordinate HL Data Segment in This Hierarchical Structure.

Loop 2100C

Pos: 050   Repeat: >1
Mandatory
Loop: 2100C   Elements:
N/A

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
050	NM1	Provider Name	M	1		Required

NM1   Provider Name

<div style="border:1px solid">

Pos: 050   **Max: 1**
Detail - Mandatory
Loop: 2100C   **Elements: 9**

</div>

User Option (Usage): Required

Use this segment to supply the full name of an individual or organizational entity.

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required

Example:

NM1*1P*2*GENERAL.HOSPITAL*****SV*PRV123456~
or
NM1*1P*1*DOE*JOHN*ANDREW*DR*JR*SV*PRV123456~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code** **Description:** Code identifying an organizational entity, a physical location, property or an individual. **Code** **Name** 1P Provider	M	ID	2/3	Required	1
NM102	1065	**Entity Type Qualifier** **Description:** Code qualifying the type of entity. **Code** **Name** 1 Person 2 Non-Person Entity	M	ID	1/1	Required	1
NM103	1035	**Name Last or Organization Name** **Description:** Provider last name or organizational name.	M	AN	1/35	Required	1
NM104	1036	**Name First** **Description:** Provider First Name. This is the billing provider from the original submitted claim. **MEDI-CAL NOTE:** The first name is required when the value in NM102='1'.	O	AN	1/25	Situational	1
NM105	1037	**Name Middle** **Description:** Provider Middle Name or initial. **MEDI-CAL NOTE:** The middle name or initial is recommended when the value in NM102='1'.	O	AN	1/25	Situational	1
NM106	1038	**Name Prefix** **Description:** Provider Name Prefix. **MEDI-CAL NOTE:** The name prefix is recommended if the value in NM102='1'.	O	AN	1/10	Situational	1
NM107	1039	**Name Suffix** **Description:** Provider Name Suffix. **MEDI-CAL NOTE:** The name suffix is recommended if NM102='1'.	O	AN	1/10	Situational	1
NM108	66	**Identification Code Qualifier** **Description:** Code used to qualify the Identification Code submitted in NM109. The code "SV" is recommended for use prior to the mandated National Provider ID. **Code** **Name** SV Service Provider Number XX Health Care Financing Administration National Provider Identifier	M	ID	1/2	Required	1
NM109	67	**Identification Code** **Description:** Code identifying a party or other code. Use this number as qualified by the preceding data element NM108. **MEDI-CAL NOTE:** Billing Provider Number on the claim. Medi-Cal uses the first 9 characters. Once NPI is implemented, Medi-Cal will use the first 10	M	AN	2/80	Required	1

Ref	**Id**	**Element Name**	**Req**	**Type**	**Min/Max**	**Usage**	**Rep**
		characters.					

Ref	**Id**	**Element Name**	**Req**	**Type**	**Min/Max**	**Usage**	**Rep**
		characters.					

Loop 2000D

Pos: 010   Repeat: >1
Mandatory
Loop: 2000D   Elements:
N/A

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
010	HL	Subscriber Level	M	1		Required
040	DMG	Subscriber Demographic Information	O	1		Required
050		Loop 2100D	M		1	Required
090		Loop 2200D	O		>1	Situational

HL Subscriber Level

Pos: 010	Max: 1
Detail - Mandatory	
Loop: 2000D	**Elements: 4**

User Option (Usage): Required

Use this segment to identify dependencies among and the content of hierarchically related groups of data segments.

Example:
HL*4*3*22*0~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL01	628	**Hierarchical ID Number**	M	AN	1/12	Required	1

Description: This ID will contain a unique number for each occurrence of the HL segment in the transaction set. The value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL02	734	**Hierarchical Parent ID Number**	M	AN	1/12	Required	1

Description: Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL03	735	**Hierarchical Level Code**	M	ID	1/2	Required	1

Description: Code defining the characteristic of a level in a hierarchical structure. All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.

Code Name
22   Subscriber

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
HL04	736	**Hierarchical Child Code**	M	ID	1/1	Required	1

Description: Code indicating if there are hierarchical child data segments subordinate to the level being described.

Code Name
0   No Subordinate HL Segment in This Hierarchical Structure.

DMG Subscriber Demographic Information

Pos: 040   **Max: 1**
Detail - Optional
Loop: 2000D   **Elements: 3**

User Option (Usage): Required

Use this segment to supply Subscriber demographic information.

Syntax:

1. P0102 - If either DMG01,DMG02 is present, then all are required

Example:

DMG*D8*19820422*F~

MEDI-CAL NOTE:

Required by Medi-Cal since the subscriber is always the patient.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DMG01	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Description: Code indicating the date format used for the date of birth within DMG02.					
		Code **Name**					
		D8 Date Expressed in Format CCYYMMDD					
DMG02	1251	**Date Time Period**	M	AN	1/35	Required	1
		Description: Use this element for the Subscriber (Patient) Birth Date.					
		MEDI-CAL NOTE: Enter recipient date of birth in CCYYMMDD format.					
DMG03	1068	**Gender Code**	M	ID	1/1	Required	1
		Description: Code indicating the gender of the Subscriber (Patient).					
		MEDI-CAL NOTE: Enter recipient gender.					
		Code **Name**					
		F Female					
		M Male					
		U Unknown					

Loop 2100D

<table>
<tr><td>Pos: 050</td><td>Repeat: 1</td></tr>
<tr><td colspan="2" align="center">Mandatory</td></tr>
<tr><td>Loop: 2100D</td><td>Elements:
N/A</td></tr>
</table>

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
050	NM1	Subscriber Name	M	1		Required

NM1 Subscriber Name

User Option (Usage): Required

Use this segment to supply the full name of an individual or organizational entity.

Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required

Example:

NM1*QC*1*PATIENT*SUZY*R*MS**MI*12345678909876~

MEDI-CAL NOTE:

This segment describes the Medi-Cal recipient (patient).

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required	1
		Description: Code identifying an organizational entity, a physical location, property or an individual.					
		MEDI-CAL NOTE: For Medi-Cal, the subscriber is always the patient.					
		Code **Name** QC Patient					
NM102	1065	**Entity Type Qualifier**	M	ID	1/1	Required	1
		Description: Code qualifying the type of entity.					
		Code **Name** 1 Person					
NM103	1035	**Name Last or Organization Name**	M	AN	1/35	Required	1
		Description: Subscriber (Patient) last name or organizational name.					
		MEDI-CAL NOTE: Recipient last name					
NM104	1036	**Name First**	O	AN	1/25	Situational	1
		Description: Subscriber (Patient) first name.					
		MEDI-CAL NOTE: Recipient first name.					
NM105	1037	**Name Middle**	O	AN	1/25	Situational	1
		Description: Subscriber (Patient) middle name or initial.					
		MEDI-CAL NOTE: Recipient middle name or initial.					
NM106	1038	**Name Prefix**	O	AN	1/10	Situational	1
		Description: Subscriber (Patient) name prefix.					
		MEDI-CAL NOTE: Recipient name prefix.					
NM107	1039	**Name Suffix**	O	AN	1/10	Situational	1
		Description: Subscriber (Patient) name suffix.					
		MEDI-CAL NOTE: Recipient name suffix.					
NM108	66	**Identification Code Qualifier**	M	ID	1/2	Required	1
		Description: Code used to qualify the identification number submitted in NM109.					
		MEDI-CAL NOTE: Please use "MI" for Medi-Cal recipient ID.					
		Code **Name** MI Member Identification Number					
NM109	67	**Identification Code**	M	AN	2/80	Required	1
		Description: Code identifying a party or other code. Use this reference number as qualified by the preceding data element NM108.					
		MEDI-CAL NOTE: Medi-Cal Subscriber (Recipient) ID. This ID can be nine, 10 or 14 characters in length.					

Loop 2200D

Pos: 090	**Repeat: >1**
Optional	
Loop: 2200D	**Elements: N/A**

Notes:

The total number of REF segments in the 2200 Loop cannot exceed three.

MEDI-CAL NOTE:

Per the 004010X093A1 Addenda, this segment is required if the subscriber is the patient. For Medi-Cal, the subscriber is always the patient.

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
090	TRN	Claim Submitter Trace Number	O	1		Situational
100	REF	Payer Claim Identification Number	O	1		Situational
100	REF	Institutional Bill Type Identification	O	1		Situational
100	REF	Medical Record Identification	O	1		Situational
110	AMT	Claim Submitted Charges	O	1		Situational
120	DTP	Claim Service Date	O	1		Situational
130		Loop 2210D	O		>1	Situational

TRN Claim Submitter Trace Number

User Option (Usage): Situational

Use this segment to convey a unique trace or reference number. The TRN segment is required by the ASC X12 syntax when the subscriber is the patient.

Example:
TRN*1*1234567890~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
TRN01	481	**Trace Type Code**	M	ID	1/2	Required	1
		Description: Code identifying which transaction is being referenced.					
		Code Name					
		1 Current Transaction Trace Numbers					
TRN02	127	**Reference Identification**	M	AN	1/30	Required	1
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. This data element corresponds to the UB-92 record 20-25, UB-92 paper form locator 23 and 837 CLM-05.					
		MEDI-CAL NOTE: Per the Addenda, this is the Patient Account Number as submitted on the claim. Medi-Cal uses the first 20 characters.					

REF Payer Claim Identification Number

<table>
<tr><td>Pos: 100</td><td>Max: 1</td></tr>
<tr><td colspan="2" align="center">Detail - Optional</td></tr>
<tr><td>Loop: 2200D</td><td>Elements: 2</td></tr>
</table>

User Option (Usage): Situational

This is the payer's assigned control number, also known as, Claim Control Number (CCN). This should be sent on claim inquiries when the number is known. By providing the information within this particular segment the search criteria is narrowed to the specific claim in question.

Example:

REF*1K*4001223330101~

MEDI-CAL NOTE:

This segment is used only if the subscriber is the patient (which is always the case for Medi-Cal). It is recommended that this segment be used when the Claim Control Number (CCN) is known, in order to narrow the search to the specific claim requested.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1

Description: Code qualifying the Reference Identification in REF02.

Code Name
1K   Payor's Claim Number

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF02	127	**Reference Identification**	O	AN	1/30	Situational	1

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.

MEDI-CAL NOTE: Claim Control Number (CCN). Please submit the entire 13 digits of the CCN where the last two bytes are the line number. For inpatient and crossover claims, put "00" in the last two bytes. For compound pharmacy claims, put "01" in the last two bytes. Do not submit a number if the CCN is unknown. This data element must match the claim, if it is present.

REF   Institutional Bill Type Identification

<div style="border:1px solid">

Pos: 100   **Max: 1**
Detail - Optional
Loop: 2200D   **Elements: 2**

</div>

User Option (Usage): Situational

This segment is the institutional bill type submitted on the original claim. The institutional bill type consists of the two position, Facility Type Code, and the one position, Claim Frequency Code.

Example:

REF*BLT*1111~

MEDI-CAL NOTE:

Per the Addenda, use this segment only if the subscriber is the patient and the bill type is being sent in the inquiry request in connection with an institutional bill.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier** **Description:** Code qualifying the Reference Identification in REF02. **Code Name** BLT Billing Type	M	ID	2/3	Required	1
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. This data element corresponds to UB-92 record 40-44, UB-92 paper form locator 4 and 837 CLM-05.	M	AN	1/30	Required	1

REF **Medical Record Identification**

User Option (Usage): Situational

This is the Medical Record number submitted on the original claim and should be sent when available.

Example:
REF*EA*12345678909876543212~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required	1
		Description: Code qualifying the Reference Identification in REF02.					
		Code Name					
		EA Medical Record Identification Number					
REF02	127	**Reference Identification**	M	AN	1/30	Required	1
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. This identifier is also found on the 837 claim in the Medical Record Number segment.					
		MEDI-CAL NOTE: Medi-Cal uses the first 20 characters.					

AMT   Claim Submitted Charges

User Option (Usage): Situational

Use this segment to indicate the total submitted charges amount.

Example:
   AMT*T3*25.97~

MEDI-CAL NOTE:
   For Medi-Cal, the subscriber is always the patient, so this segment is required.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
AMT01	522	**Amount Qualifier Code** **Description:** Code to qualify amount in AMT02. **Code** **Name** T3 Total Submitted Charges	M	ID	1/3	Required	1
AMT02	782	**Monetary Amount** **Description:** The claim total submitted charges. **MEDI-CAL NOTE:** Total Claim Charge Amount. Medi-Cal processes non-compound pharmacy, long term care, outpatient and vision claim lines individually as claims, so the line charge amount should be used for inquiry on these claim types. For all other claim types (inpatient, compound pharmacy and crossovers), use the total charge for the claim. Use a decimal point to show cents. Example: 56.45 The maximum value that can be processed by Medi-Cal is 9999999.99.	M	R	1/18	Required	1

DTP   Claim Service Date

<table>
<tr><td>Pos: 120</td><td>Max: 1</td></tr>
<tr><td colspan="2" align="center">Detail - Optional</td></tr>
<tr><td>Loop: 2200D</td><td>Elements: 3</td></tr>
</table>

User Option (Usage): Situational

Use this segment to specify a date period. For institutional claims, the date is the statement from and through date. For professional claims, the date is the claim from and through date.

Notes:

Required for institutional claims. The date is the statement from and through date.

For professional claims this will be the claim from and through date. If claim level date range is not used then the Line Service Date at Loop 2210D is required.

Example:

DTP*232*RD8*20040501-20040502~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required	1
		Description: Code specifying type of date in DTP02.					
		Code Name					
		232 Claim Statement Period Start					
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Description: Code indicating the date format. If the date is a single date of service, the begin date equals the end date.					
		Code Name					
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD					
DTP03	1251	**Date Time Period**	M	AN	1/35	Required	1
		Description: The claim service period.					
		MEDI-CAL NOTE: Claim From and through dates of service in CCYYMMDD-CCYYMMDD format. For one-day services, the through date is the same as the from date.					
		Example: 20040617-20040620					
		or 20040617-20040617 (one-day)					
		Medi-Cal limits this date range to 90 days.					

Loop 2210D

Pos: 130	**Repeat: >1**
	Optional
Loop: 2210D	**Elements: N/A**

MEDI-CAL NOTE:

Compound pharmacy, Inpatient and crossover claims inquiries should not be done at a service line level. Service line information will not be returned for these claim types, since they are not processed on a per-line basis.

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
130	SVC	Service Line Information	O	1		Situational
140	REF	Service Line Item Identification	O	1		Situational
150	DTP	Service Line Date	O	1		Situational

SVC Service Line Information

<table>
<tr><td>Pos: 130</td><td>Max: 1</td></tr>
<tr><td colspan="2">Detail - Optional</td></tr>
<tr><td>Loop: 2210D</td><td>Elements: 4</td></tr>
</table>

User Option (Usage): Situational

Use this segment to supply payment and control information to a provider for a particular service. This segment is required if loop is used because it is the first segment in Loop ID 2210 (Service Line Information).

Example:

SVC*HC:99214:XX*14.35*1~   OR SVC*NU:71X*300*1~ OR

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SVC01	C003	**Composite Medical Procedure Identifier**	M	Comp		Required	1
		Description: To identify a medical procedure by its standardized codes and applicable modifiers.					
		MEDI-CAL NOTE: SVC01 will contain the procedure code submitted on the claim.					
	235	**Product/Service ID Qualifier**	M	ID	2/2	Required	1
		Description: Code identifying the type/source of the descriptive number used in SVC01-2.					

Code Name

HC   Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

User Note 1:

Because the CPT codes of the American Medical Association are also Level 1 HCPCS codes, the CPT codes are reported under the code HC.

ID   International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure

N4   National Drug Code in 5-4-2 Format

Description: Five-digit manufacturer ID, four-digit product ID, two-digit trade package size

User Note 2:

240: National Drug Code by Format

ND   National Drug Code (NDC)

NU   National Uniform Billing Committee (NUBC) UB92 Codes

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
	234	**Product/Service ID**	M	AN	1/48	Required	1
		Description: Identifying number for a product or service.					
		MEDI-CAL NOTE: Enter the five-digit procedure code, three to four digit revenue code or 11 digit National Drug code. For compound pharmacy claims, enter "0". Do not include modifiers. Inpatient and crossover claims inquiries should not be done at a service line level.					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Description: This identifies special circumstances related to the performance of the service.					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Description: This identifies special circumstances related to the performance of the service.					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Description: This identifies special circumstances related to the performance of the service.					
	1339	**Procedure Modifier**	O	AN	2/2	Situational	1
		Description: This identifies special circumstances related to the performance of the service.					
SVC02	782	**Monetary Amount**	M	R	1/18	Required	1
		Description: Original line item Charge Amount.					
		MEDI-CAL NOTE: Line item billed amount. Use a decimal point to show cents. Medi-Cal uses the first 10 characters. Example: 23.99					

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		The maximum value that can be processed by Medi-Cal is 9999999.99.					
SVC04	234	**Product/Service ID**	O	AN	1/48	Situational	1
		Description: Revenue Code.					
		MEDI-CAL NOTE: Medi-Cal uses the first four characters.					
SVC07	380	**Quantity**	O	R	1/15	Situational	1
		Description: Original Units of Service Count.					
		MEDI-CAL NOTE: Medi-Cal will use the first 11 characters. The maximum value is 9999999.999 for pharmacy. Non-pharmacy claims must use whole numbers.					

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
		The maximum value that can be processed by Medi-Cal is 9999999.99.					
SVC04	234	**Product/Service ID**	O	AN	1/48	Situational	1
		Description: Revenue Code.					

REF Service Line Item Identification

Pos: 140	Max: 1
Detail - Optional	
Loop: 2210D	**Elements: 2**

User Option (Usage): Situational

Use this segment to specify identifying information.

Example:

REF*FJ*12345678900~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
REF01	128	**Reference Identification Qualifier** **Description:** Code qualifying the Reference Identification in REF02. **Code** **Name** FJ Line Item Control Number	M	ID	2/3	Required	1
REF02	127	**Reference Identification** **Description:** Line Item Control Number.	M	AN	1/30	Required	1

DTP Service Line Date

User Option (Usage): Situational

Use this segment to specify the line date of service range.

Example:
DTP*472*RD8*20040501-20040502~

MEDI-CAL NOTE:
This segment must be present when the 2210D loop is used.

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
DTP01	374	**Date/Time Qualifier**	M	ID	3/3	Required	1
		Description: Code specifying type of date.					
		Code Name					
		472 Service					
DTP02	1250	**Date Time Period Format Qualifier**	M	ID	2/3	Required	1
		Description: Code indicating the date format. If the date is a single date of service, the begin date equals the end date.					
		Code Name					
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD					
DTP03	1251	**Date Time Period**	M	AN	1/35	Required	1
		Description: Service line date range.					
		MEDI-CAL NOTE: Detail line from and through dates of service in CCYYMMDD-CCYYMMDD format. For one-day services, the through date is the same as the from date. Example: 20040617-20040620 or 20040617-20040617 (one-day) Medi-Cal limits this date range to 90 days.					

SE Transaction Set Trailer

Pos: 160	**Max: 1**
Summary - Mandatory	
Loop: N/A	**Elements: 2**

User Option (Usage): Required

Use this segment to indicate the end of the transaction set and provide the total count of segments included in a transaction set.

Example:
SE*15*0535~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
SE01	96	**Number of Included Segments**	M	N0	1/10	Required	1
		Description: Use this number to indicate the total number of segments included in the transaction set inclusive of the ST and SE segments.					
SE02	329	**Transaction Set Control Number**	M	AN	4/9	Required	1
		Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. This data value must be identical to ST02.					
		MEDI-CAL NOTE: A user-assigned number that matches the value in ST02.					

GE Functional Group Trailer

Pos:	**Max: 1**
Summary - Mandatory	
Loop: N/A	**Elements: 2**

User Option (Usage): Required

Use this segment to indicate the end of a functional group and to provide control information.

Example:
GE*1*999999999~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
GE01	97	**Number of Transaction Sets Included** **Description:** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	M	N0	1/6	Required	1
GE02	28	**Group Control Number** **Description:** Assigned number originated and maintained by the sender. This control number must be identical to the same data element in the associated functional group header, GS06.	M	N0	1/9	Required	1

IEA   Interchange Control Trailer

User Option (Usage): Required

Use this segment to define the end of an interchange of zero or more functional groups and interchange-related control segments.

Example:
IEA*1*123456789~

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage	Rep
IEA01	I16	**Number of Included Functional Groups** **Description:** A count of the number of functional groups included in an interchange.	M	N0	1/5	Required	1
IEA02	I12	**Interchange Control Number** **Description:** A control number assigned by the interchange sender. This data value must be identical with ISA13. **MEDI-CAL NOTE:** A number, right justified and zero filled.	M	N0	9/9	Required	1

Appendix

All Included Elements in All Included Segments

Id	Elements	Used in Segments
C003	Composite Medical Procedure Identifier	SVC
I01	Authorization Information Qualifier	IEA, ISA
28	Group Control Number	GE, GS
66	Identification Code Qualifier	NM1
67	Identification Code	NM1
96	Number of Included Segments	SE
97	Number of Transaction Sets Included	GE
98	Entity Identifier Code	NM1
124	Application Receiver's Code	GS
127	Reference Identification	REF, TRN
128	Reference Identification Qualifier	REF
142	Application Sender's Code	GS
143	Transaction Set Identifier Code	ST
234	Product/Service ID	SVC
235	Product/Service ID Qualifier	SVC
329	Transaction Set Control Number	SE, ST
337	Time	GS
353	Transaction Set Purpose Code	BHT
373	Date	BHT, GS
374	Date/Time Qualifier	DTP
380	Quantity	SVC
455	Responsible Agency Code	GS
479	Functional Identifier Code	GS
480	Version / Release / Industry Identifier Code	GS
481	Trace Type Code	TRN
522	Amount Qualifier Code	AMT
628	Hierarchical ID Number	HL
734	Hierarchical Parent ID Number	HL
735	Hierarchical Level Code	HL
736	Hierarchical Child Code	HL
782	Monetary Amount	AMT, SVC
1005	Hierarchical Structure Code	BHT
1035	Name Last or Organization Name	NM1
1036	Name First	NM1
1037	Name Middle	NM1
1038	Name Prefix	NM1
1039	Name Suffix	NM1
1065	Entity Type Qualifier	NM1
1068	Gender Code	DMG
1250	Date Time Period Format Qualifier	DMG, DTP
1251	Date Time Period	DMG, DTP
1339	Procedure Modifier	SVC